



Assessment, Feedback, Incentives and Exchange (AFIX) Project for Ohio

AFIX Notification and Demographic form

Agency Information:

Person conducting the AFIX:

Local health district:

Assessment Date:

Feedback Date:

Follow-up Date:

Assessment Age: Pediatric (24-35 months) Adolescent (13-15 years)

Practice Information:

Provider Site Name:

Practice Contact Name:

Address:

Street Address

City

Zip

Office phone:

Fax:

Email address:

VFC 5-digit number*: (obtain this # from your Immunization Consultant)

*If this is NOT a VFC site please see the instructions in the AFIX binder section 2 page 5

Has an AFIX been completed at this site before? Yes, year: No

Type of Assessment: Impact SIIS extract Manual Entry HDIS extract

Provider type: Private Practice FQHC/RHC

Local health district Other Public

Send to:

AFIX Coordinator

Ohio Department of Health, Immunization Program

35 E Chestnut Street, 6th Fl.

Columbus, Ohio 43215

Fax: 614.728.4279